Uptake of medicines and prescribing patterns in the palliative care schedule of the Pharmaceutical Benefits Scheme

The palliative care schedule is coming of age as evaluation data become available

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Palliative care is a valued aspect of clinical care, especially in general practice.[1] On average, a full-time equivalent Australian general practitioner will provide care for three to five people who die an "expected" death each year — that is, people who die from end-stage organ failure, neurodegenerative disease, AIDS or cancer.[2]

Improving affordable community access to key medicines for palliation is a priority in the National Palliative Care Strategy, which has been endorsed by all Australian governments since 2000.[3] Through the Palliative Care Medications Working Group (which takes a whole-of-sector approach that includes government, industry, clinicians and consumers), the first patient-defined schedule of the Pharmaceutical Benefits Scheme (PBS) was launched in February 2004, with the number of listings steadily growing since that time.[4] This list of medicines — the palliative care schedule — was developed within existing legislation and regulations underpinned by the National Medicines Policy, which includes key tenets of access to medicines, quality use of medicines and affordability of medicines.[5-7]

Priority palliative care medicines had been defined in 2000, when a survey of Australian palliative care clinicians was done to seek advice on the pharmacological management of the 22 most frequently encountered symptoms and the way that medicines for these symptoms are used.[8] One outcome of the survey was a list of unsubsidised medicines considered to be essential to improve community-based palliative care. The patent had expired on almost all of these medicines, limiting the commercial interests of pharmaceutical companies. Key features that were part of the design of the palliative care schedule in the PBS included:

- augmenting the availability of many of these medicines that already had a general listing
- defining palliative care patients
- making a broad range of medicines available
- ensuring that any clinician could write an initial prescription for up to 4 months, and could write subsequent prescriptions for 4 months if the patient's condition had been discussed with a palliative care clinician (these periods are based on national census data[9]), or that ongoing monthly prescriptions were available.

The Australian Institute of Health and Welfare recently released the first publicly available data on the costs of medicines listed on the palliative care schedule.[10] The schedule

provided more than $12 million worth of subsidised medicines to people at the end of life — over 150 000 prescriptions — between July 2007 and June 2012. During the 2011–12 financial year, 19 000 palliative care patients received at least one subsidised prescription for palliative care medicines. The age and geographic distribution of the patients for whom prescriptions were written closely mirror the demographic profile of people referred to specialist palliative care services in Australia, including the one-third of those who are under the age of 65 years.[9,10]

More than 80% of prescriptions on this program were written by GPs in the 2011–12 financial year. In order of proportion of prescriptions written, classes of medicines included: laxatives, analgesics, antiepileptics, psycholeptics, antiemetics and antinauseants, drugs for functional gastrointestinal disorders, anti-inflammatory and antirheumatic products, and stomatological preparations.

More than 90% of opioid prescriptions were for the initial 4 months, and 66% of paracetamol prescriptions were for the initial 4 months. This reflects known pain trajectories at the end of life and suggests that the schedule is being used appropriately for pain medicines.[11]

Nationally, 161.3 subsidised palliative care-related prescriptions were dispensed per 100 000 population in the 2011–12 financial year.[10] Prescription rates ranged from 99.3 per 100 000 population in the Australian Capital Territory to 250.3 per 100 000 population in Tasmania. Also, there was a more than a twofold difference in the rate of prescribing for opioids from the palliative care schedule at the end of life across the jurisdictions, and there were similar variations for most other classes of medicines prescribed. Although these are unadjusted data, adjusting for age, sex and diagnosis is unlikely to explain the differences. Possible explanations include: clinicians preferring to use using general listings in the PBS or Repatriation Pharmaceutical Benefits Scheme in some settings (ie, poor uptake of the schedule); genuine variation in use of medicines that is not easily explained by clinical characteristics; difference in levels at which public hospitals dispense medicines; and variation in the proportion of care provided in primary and specialist care services.

The uptake of the program is quite low. On average, for people who had any prescriptions written, only 1.9 prescriptions were written per person.[12] In the last full year reported, only 19 293 people had any prescriptions written. Conservatively, the number of people who had any prescriptions written is fewer than half of the number of those predicted to die an expected death in Australia annually, and this estimate is reinforced by the number of people who currently are seen by specialist palliative care services.[12] In the last 40 days of life, there is a 50% increase in prescribing for symptom control medicines, from a baseline average of 2.5 medicines.[13] Prescriptions written from the general section of the PBS therefore still account for the majority of prescriptions written for people at the end of life. Further, this suggests that the palliative care schedule is being used appropriately for specific indications or increased volumes per prescription.

The federal government is to be commended because this schedule is delivering on the original policy intent of making medicines essential for symptom control more affordable for people at the end of life. A key sign of the long-term viability of this initiative is that there have been specific applications by pharmaceutical companies for listings in the schedule.

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